FORMAL QUALITY-ASSESSMENT AND UTILIZATION-REVIEW PROGRAMS: THEIR EFFECTS ON THE BASIC TRANSACTIONS OF MEDICAL EDUCATION*

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SEVERAL generalizations can be made about the ways in which formal assessments of the quality of care affect medical education and in which medical education fosters a high quality of medical care.

First, any analysis of the quality of care provided to patients does more than give direction to the clinical phases of medical education or test the effectiveness of that education—it is medical education. Clinical medical education is education in the care of patients, which, of course, only reaches its objective if that care is demonstrably of high quality.

Second, while the assessments of the results of care given to the sick has always been fundamental to clinical medical education, that assessment has become increasingly sophisticated and now has taken the form of a mechanism for simultaneous feedback which is becoming a regular part of the process of care. A generation ago, the principal mode of assessing the quality of care was through autopsy (almost inevitably after the fact) and the pathologist was the final arbiter. Today the percentage of autopsies done in teaching hospitals has been drastically reduced, largely because diagnosis and the evaluation of treatment have been refined to a point where the autopsy usually is anticlimactic or, at best, confirmatory. For example, in the 1940s nearly two thirds of the Cabot cases reported weekly in the *New England Journal of Medicine* had been autopsied, whereas in 1974 only approximately 30% of the cases presented and discussed were based on autopsies.

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Third, in the context of medical education the formal processes of review of the quality of care and of utilization reinforce the learner's understanding that professional practice occurs in a matrix of professional collaboration and interdependence. This affects the student's concept of the nature of professional work and his concept of himself as a professional person. Most specifically, it helps him to understand that as a practicing doctor his individual responsibility for his patient is supplemented by a more diffuse institutional and peer-group responsibility for the patient; similarly, it defines his responsibility as a member of the staff to all of the patients in the hospital or as a member of the medical profession to all of the people of the community. In terms of the ideas that I shall develop, the student-physician learns that the basic medical contract which the patient has with him is supplemented and in some ways reinforced by implicit or explicit contracts which his peers and the institution have with this same patient. Quality assessment by peers (peer review) and utilization review are new contractual responsibilities.

Fourth, the quality-assurance and utilization-review processes in some measure will demythologize professional activities and decisions and will open the rationale of these transactions to public scrutiny.

Finally, these programs assessing the quality of care are likely to sharpen the responsibility which individual medical staff members have for the care of individual patients, because of the enhanced power of charity patients in the teaching hospital, thus bringing about some shifts in traditional patterns of clinical responsibility in teaching hospitals. Specifically, we can anticipate that this process, together with the recently acquired purchasing power of the medically indigent, will pinpoint the responsibilities of medical staff members, residents, and medical students in the care of individual patients.

Each of these assertions merits more extended analysis, which I can best contribute to by returning to some fundamental considerations of the nature of medical practice and the basic transactions of practice; the nature of medical education, its institutions, and the basic transactions of that process; and, finally, the way that the practices and institutions of medical education and medical practice reciprocally affect one another and the part which quality assessment plays.

These ideas can best be developed by building them around the concept of the basic medical contract and the associated, complemen-

tary contracts and understandings which together compose modern medical care and personal health services. To establish a common ground to this discussion, I shall start with a little-noted but pervasive reality of medical practice and medical care. I do this in the spirit of discovery remarked by Thomas H. Huxley in his famous essay "On a Piece of Chalk," in which he held an ordinary piece of chalk up to the light and declared that by careful analysis of the commonplace we might be led to profound understanding. My piece of chalk might be described as the best-kept secret of medical practice. Actually, it is not so much a secret as an ignored or overlooked feature; the reasons for that oversight are a part of the story.

I shall start by drawing your attention to a commonplace observation about medical practice—albeit a subtle one—namely, that there are widely differing views as to what medical practice is, what medical care consists of, what the real work of the doctor is, and what people consider to be properly in the realm of medicine—why people go to a doctor. If these differing views about the nature of medical care were limited to the laity, we might disregard them as indicating a lack of sophistication, but the diversity of opinion also is apparent among physicians. Indeed, with respect to primary care particularly, beyond certain obvious incidents such as a laceration which requires suturing, a foreign body which requires removal from the eye, or a thrombosed hemorrhoid which requires incision, doctors each provide care to individual patients according to the doctor's own concept.

Doctors' differing views about the nature of a doctor's work might suggest that they care for different categories of patients. In fact, there appears to be less diversity in the way physicians in the same specialty view medicine than is true for the profession as a whole. Each doctor often attracts a certain type of patient and hence each tends to have a unique set of experiences. Acknowledging all this, there remains the stubborn fact of widely different concepts of medical care.

These different ideas about the work of a doctor are based on our individual ideas about the social role of the physician, and these, in turn, are based on our understanding of what patients need and what we are able to provide. The differences are apparent during diagnosis[1] ". . . since that often involves a kind of negotiation between patient and doctor in which offers of a symptom and counter-offers of an explanation or diagnosis or treatment are made and some sort of an agreement

between the two parties is reached. There are many forces acting in such transactions to shape the definition of the trouble or illness and to determine what therapy is agreed upon." One doctor, for example, defines medical responsibilities for such conditions as cirrhosis or alcoholism differently from another, and "there are great individual variations in expectations about medical care and the acceptance of the intrusion of diagnostic inquiry among patients and families as well as variations among physicians."[1]

I do not mean to exaggerate the variations involved. For example, our students recently discussed a case which variously could have been described as cardiogenic shock, coronary thrombosis, ventricular tachycardia, ventricular aneurysm, loss of father and husband, or loss of economic stability. Diagnosis is much more than a doctor figuring out what is wrong. As noted, it involves a kind of negotiation. Included in this negotiation are the value systems of the individual patient and doctor. Also included are the values and, ultimately, the economic priorities of the society. The fact that the physician acts as a rationing agent on behalf of society almost as much as he acts on behalf of his patient is largely ignored. In deciding what x rays, laboratory tests, or hospital care the patient should have, the physician also is deciding what societal resources to utilize on the patient's behalf. First, however, the doctor decides how much of a physician's attention the patient requires or merits. Until now, these matters have not been widely understood and the agreements which were negotiated have been private matters. Changing circumstances in medicine and hospitals erode the simplicity and privacy of the human transactions. New approaches and conventions are required to maintain the individual character of medical care in the highly organized and industrialized system which has been developing. But I am getting ahead of my story.

The medical convention for coping with this diversity until now has been deceptively simple, in that "we have merely emphasized the primacy of the relation between patient and doctor in medical care."[1] Our analysis of the individualized character of much medical care and the idiosyncratic understanding between the patient and doctor on which this is based have gone little beyond that. For good or ill, the idea that the doctor-patient relation is an indispensable element in effective medical care is perceived by the public as largely a self-serving medical concept which has become an unconvincing cliche in our so-

ciety. "Nonetheless, it is important to remind ourselves that since medical care is still largely a matter of one person who feels ill asking another for help the relationship is important."[1] Sir James Spence stated this very clearly:[3]

> The real work of a doctor is only faintly realized by many lay people. It is not an affair of health centers or public clinics or operating theaters or laboratories or hospital beds. These techniques have their place in medicine but they are not medicine. The essential unit of medical practice is the occasion when in the intimacy of the consulting room or sick room a person who is ill or believes himself to be ill seeks the advice of a doctor who it [sic] trusts. This is a consultation and all else in the practice of medicine derives from it.

What has just been described as a relation or a consultation is best understood as a professional contract. It might be called the basic medical contract.[2] In my view, "the hundreds of thousands of small transactions and human confrontations which daily make up medical care in this country are best conceived of as individually negotiated two party contracts. Much of what we have called the doctor/patient relationship is more accurately described as a medical contract."[1] Our persistence in using the term "the doctor/patient relationship" and the resultant obscurity of the existence of a contract between each doctor and patient are hampering medical progress. "The concept of a special relationship between doctors and patients has come to be understood by the public and some of our professional co-workers as bolstering a claim by the medical profession to elite status rather than as a commitment to serve the person who is the patient . . . and also it has not been sufficiently flexible to accommodate the more complex arrangements for personal health services which have been developing."* As the care of patients has become more complex, changes in and supplementation of the basic two-party contract have been developing.

"Some authorities feel that the basic two-party contract between doctor and patient should be and will be supplanted."[1] It seems evident, however, that the two-party contract wherein two individuals negotiate an understanding of what is to be done and in the process

*The concept of medical contracts discussed in this paper is covered in greater detail in maternal previously published in Chapters 4 and 15 (pp. 41-49 and 148-57, respectively) in *Hippocrates Revisited.*[1] This paper draws extensively on those chapters.

reconcile the value systems of the individual patient and his family and those of medicine "remains central in medical care and is essential to its regular effectiveness."[1]

I have emphasized that the central unit or transaction of medical care and personal health services is the basic medical contract. The remainder of my discussion turns around this concept, concerning which I shall develop three general themes. First, I shall relate this concept to medical education and the professionalization of the physician. Second, I shall place this contract in context with other arrangements or understandings which comprise the entire system of personal health services, including assessments of quality and review of utilization, since what has come to be called the system of medical care may be better understood as a widening series of understanding or contracts which are built around or supplemental to this basic medical contract. Third, I shall note some implications of these contracts to issues relating to medical care, medical education, and medical schools and comment on the current effectiveness of medical education in preparing students for functioning amid these realities.

First, a physician's training consists not only of acquiring a progressively enlarged data base and set of skills, but also of encountering a graded series of patient models and of gaining from these models perspectives on the dimensions of responsibility to his patients. This succession of progressively more complete and complex patient models provides the medical student with a conceptual framework and a repertory of skills. Often the first patient model which a student is introduced to in medical school is the cadaver. Although the cadaver is complex, it is easier to understand than the living patients whom the student will ultimately work with as a practitioner. Subsequently, the student encounters other fragments or perspectives of the patient as tissue specimens from normal and diseased organs, in "heart-lung preparations," in specimens of blood and urine, etc.

In the course on physical diagnosis patient models may take the form of simulated heart sounds, synthetic pelves, or motion pictures or video-tapes of patients. These all are understood to be something less than a whole patient. Sometimes, when students then deal with their first actual patients we are not discriminating enough as to what makes up a complete patient and what medical responsibility consists of, particularly in university hospitals. Thus,

the first human patients the student examines in his physical diagnosis course and later talks to are in a sense serving as manikins for him. His interaction with them is quite perfunctory. He plays little or no professional role with them and undertakes no professional responsibility.

Progressively, however, the student is introduced to increasingly "human" human beings. They begin to talk back, to interact, and ultimately to negotiate with him. . . .

In clinical work the student moves progressively from perceiving or diagnosing his patient as a case of pneumonia (no small feat in itself) to understanding him in human terms—first as a feeling human being and then as a part of a complex fabric or network of family, marital, social, and occupational contexts.

Before he can regularly perceive and deal with the whole patient the student must achieve some excellence in the techniques required in handling all of the simpler patient models, and this takes time and experience. Until he has acquired sureness in his professional functioning at a simpler level of defining the patient, the student or physician is limited in his capacity to move to the next level of complexity. He is inclined to define the patient at no higher level of complexity than he can comfortably handle, even though such a level may be less than optimal for the patient.

To be fully effective in his professional role, the physician must become able to view and understand the patient at the level which is most helpful.

The summation of all of this comes when the doctor perceives the patient as the other contracting party, with all the dignity, humanity, and power that the capacity to enter a contract implies. With experience and maturity, the physician comes to perceive this as a transaction where systems of value intersect, with the values of the patient on one hand and the values of medicine, the doctor, and society on the other.

The principal goal of medical education is to develop in a physician the professional capacity for entering into contracts with patients. The proscriptions of behavior in the Hippocratic oath can be understood as the fine print appended to every medical contract drawn up during 2,000 years of Western civilization. Now, because of the growing complexity of the arrangements for medical care and health services, that

professional goal, essential as it is, is no longer the endpoint in the student's professionalization. New codicils have been added.

This brings me to my second theme, namely, the relation of this basic medical contract to other arrangements, understandings, or, as I prefer to call them, additional contracts which now exist or are developing as a framework for our system of medical care.

As I said earlier, some authorities believe that the basic two-party contract between doctor and patient should be and will be supplanted. They point to the fact that the third party concerned with financial arrangements is already nearly a universal presence in transactions between doctors and patients. They point out that institutions such as hospitals and medical groups are beginning to provide care for individual patients. They point to such factors as the progressive changes in the scope of the individual doctor's responsibility for patients and families which have resulted from specialization and changing public expectations regarding care, the increasing amount of care provided by professional workers other than physicians, the changing role of the hospital and the hospital emergency room, changing public attitudes about the hospital, and the quality-of-care review.

What is occurring is not so much change in or replacement of the two-party contract per se as supplementation of the basic two-party contract by other contracts, social understanding, or agreements. During the past five to 10 years, the complementary character of this development has been obscured somewhat by the tendency of various partisan groups such as hospitals, physicians, and third-party insurers to each claim the central or pivotal function for themselves rather than recognizing their less pretentious role as providers of a series of complementary functions, each of which is a part of the system. These functions also are contractual.

The development of our system of medical care will be facilitated if we perceive that the basic medical contract exists in a matrix of other supplemental understandings or contracts. All medical students should understand this and use it as a guide to what they need to learn. Just as they need a progression of patient models to develop a sophisticated view of professional function, so too they need to develop progressive sophistication about the matrix of understandings which now make up medical care and personal health services.

One of the most obvious of the new contracts involves the hospital.

It is now clear to all that the community hospital has a contractual obligation to any patient who comes to it or is sent to it by a doctor. The legal basis for this was determined by the Darling case in Illinois in 1965. That decision had far-reaching implications. It held up to public view—and to hospital administrators and boards of trustees—the contractual reality of this responsibility to patients. The decision merely reflected existing public understandings. It did not go beyond what people had come to expect. Thirty years ago, when I started in medical practice, people discussing medical care spoke in terms of "doctors and nurses." After World War II they began to use the phrase "doctors and hospitals." Now they usually speak of "hospitals and doctors." These shifts in phrasing may be subtle but they are not trivial. They reflect changes in public understanding of how service is provided in the role of institutions in comparison with that of physicians.

As I shall discuss later, in the Darling case it was apparent that the court was aware of the dereliction by the medical collective, i.e., the medical staff. We may assume that as the medical staff becomes more of an identifiable factor in the provision of care and has more defined responsibilities for peer review and supervision, other suits will focus on medical collectives, and at some point these collectives will be held responsible for the care which they provide.

"It is sometimes said (particularly by those who might be said to have a hospital view of things) that the Darling decision made the hospital trustees totally responsible for the care of individual patients provided within the hospital walls . . . [Rather] what society has recognized is that medical care by a physician now occurs in a more or less tightly organized system . . . [and] a more realistic and accurate portrayal of actual social expectations [is] to say that the hospital's responsibility in such a system is a back-up responsibility"[1] to that of the doctor. It is a fail-safe device. In the terms I am using here "the two party contract between the individual patient and the doctor remains . . . fundamental; the hospital's contract [with patients or the community] is complementary to that. . . ."[1]

Beyond the hospital's contracts with individual patients, we may note an obligation or a public trust of the hospital, the responsibility for coordinating or insuring the availability of care to a defined population or community.[1]

As yet this is mostly in the thinking and talking stage, although

> more and more hospital administrators and trustees are doing their long-range planning in terms of regions, networks of service and defined populations. However, it is precisely by means of such conceptualizing and planning that expectations in medical care have been progressively redefined over the past generation. The public trust which the hospital holds in regard to personal health service is now evolving toward an implicit social contract, that is, an unwritten understanding existing in society concerning the community's support of the institution and the institution's obligation to the community.

Of course, in large cities such as New York and Chicago it has not been difficult for hospitals to avoid a clear identification with a community. This was particularly true with respect to university hospitals and some religiously and ethnically oriented hospitals. However, in recent years many hospitals have found that the community itself has come to identify the hospital as belonging to the community and has begun to define the hospital's obligation to the community.

Turning now from the doctor-patient and hospital-patient contracts, we come to a new set of understandings regarding the responsibilities of physicians' groups with respect to the patients of professional peers. With the coming of the Professional Standards Review Organizations (PSRO), these responsibilities have been made more explicit. The picture has changed quickly with the passage of the PSRO legislation, but understanding has developed more slowly. It has been noted earlier that in the Darling case the court was aware of the medical staff's abrogation of responsibility and in effect held the trustees responsible for it. Now, with the prominence of defined professional responsibility for peer review and utilization review, the medical staff has a corporate responsibility which is more generally visible and more generally understood. The rapidity with which this has come about is suggested by the changes in understanding which have come about since the following passage was written three years ago:[1]

> Is there an expectation that physicians collectively have responsibility for providing required medical services for a given population? Does a county medical society, for instance, collectively have a responsibility for the care any member of that society provides a patient or patients? As another example, does the medical staff of a hospital have collective responsibility for

the care provided individual patients in that hospital? I believe that physicians would answer "yes" to at least this last question. Would the general public answer "yes" as well? That is less certain. County medical societies and hospital staffs up to now have not in fact acted collectively in these matters. At least they have not been visible to the community as active agents in the medical scene and correspondingly are not part of the public's understanding or expectation. . . .

Social understandings have not yet crystallized regarding the implications of the fact that each physician now carries out only a portion of the generic medical function and that it is only when doctors are recombined into a balanced medical group or linked in some kind of formal network that a genuine synthesis of medical skill is available to the patient. We have not as a profession fully recognized or accepted this fact ourselves nor formalized the professional usages involved. Those usages will develop further, and patients (and society) may come to fully expect that obtaining the services of a single physician implies the dependable availability of a balanced group of various medical experts as a regular extension of that doctor's knowledge and skill. At such a time a social understanding will have developed and the patients will in effect have an implicit contract with the group of which a particular physician is a part.

Some medical groups, particularly but not exclusively those providing prepaid care, now make contracts directly with the patient or perhaps with groups of "consumers." In such instances unless specific provision is made for maintenance of a defined individual medical responsibility for specific individuals or families, there may be an avoidance of or an alteration in the basic two-party contract between individual and patient. The patient, in effect, while gaining a contract with the group, may lose a contract with a primary physician, resulting in risk of disorganization, incompleteness, and lack of continuity in care. In such groups the phenomenon of "easy disengagement" of the doctor from the patient or the doctor's careful adherence to a 9 to 5 workday or a 5-day workweek are the hallmarks of arrangements for care which lack the basic doctor-patient contracts.

> Until now, the responsibility which doctors collectively might have either for the care of individual patients or for the availability and quality of care to the community has not been well understood or at least not clearly stated by either profession or the public. Now the contractual responsibility which hospitals have for care has been legally defined and physicians are feeling the threat of progressive hospital "control" of their professional work.

Because of PSRO and these other trends, the collective responsibility of physicians as members of a hospital medical staff or, perhaps, a county society or a group practice, for the care of individual patients will be defined explicitly.

To complete the list of arrangements or contracts which stitch together the present system of personal health services in medical care in the United States we need to return to the fiscal contract involving third-party payors. There is some tendency—reflected in the term third party—to consider this contract as an intrusion into the basic two-party contract rather than as agreement in its own right which, as suggested earlier, is complementary to the two-party contract.

For some years it has been customary for some third-party payors to refer to themselves as "purchasers of medical care" or "purchasers of health care" rather than as "third-party payors." However, most of these agents have functioned primarily as payors or dispersing agents, rather than as purchasers. A purchaser of a service is someone who is concerned with obtaining that service and with its cost and its quality. This distinction has an important bearing on the nature of the contract. As far as the individual patient is concerned, third parties act primarily as payors, but for the group as a whole their role may be more nearly that of purchasers. In recent years the leaders of Blue Cross and Blue Shield have been sharply criticized in Congressional hearings and public forums for not acting more clearly in the interest of those paying for or receiving care or of the public as a whole in keeping costs down. Obviously, these groups have a major stake in utilization-review procedures.

I turn now to the third theme concerning the implications of this medical contract and the widened contractual arrangement for medical education and medical schools. Until relatively recently, medical education in the United States was closely linked to the charity system of

medical care and to public or university hospitals. Although some deny it, the charity system of care was characterized by extremely loose doctor-patient contracts; and, in a sense, the system of medical education in the United States depended on that circumstance and exploited it. Patients in teaching hospitals often did not know who their doctor was—not merely did not know his name, but simply were unable to identify any responsible physician; these patients often were called ward patients, meaning the hospital's patients.

Now the system of charity care may be coming to an end as all segments of society increasingly have been granted medical purchasing power. Patients are acquiring more power in these institutions. Now, many of these institutions are in trouble because their medical staffs have not accommodated themselves sufficiently or with sufficient rapidity to the new reality in which they must individually accept contractual responsibility for patients who formerly were dealt with under what might be called the "collusion of anonymity" which characterized such hospitals. In effect, circumstances require that the faculty or, more accurately, the medical staff must go into practice within the medical center; in doing so they acquire new identities as practitioners.

The loosely held contracts of the old charity system of care had one advantage. They permitted medical students to move into at least a quasi-contractual role with patients. On the other hand, the tightly held contracts which usually characterize private practice—particularly with respect to surgical procedures—contain seemingly crisp and incisive obligations which leave little room for the student physician at any level to acquire, by progressive assumption of the professional role and contractual responsibility with patients, those experiences which are essential to his professional maturation. None of the parties in such a milieu can be expected to accommodate to the participation of yet another party—the uneducated student.

However, here the student, the educational process, and the educational institution also have something in their favor. The public seems to have moved much further and more rapidly in this regard than have the medical schools or the medical profession as a whole. The reason for the vast increase in the number of medical schools in the United States during the past 10 years is that individual communities have worked hard to develop medical schools of their own. This was not motivated by what everybody talks most about, the need for more

physicians in this country, or even by the need for more primary care physicians. The real reason was that a large number of communities with substantial concentrations of populations have come to realize that without a generic relation to medical education their system of medical care (i.e., the hospitals and doctors) would not be able to renew and sustain itself and inevitably would deteriorate. In short, the people in the communities and perhaps to a lesser extent the doctors in the community hospitals appear ready to build the processes of medical education into the system of medical care.

Most medical schools now have developed into academic medical networks which involve a number of community hospitals and a recognizable segment of the system of care. It is in these that much of the student's learning about the new realities or contracts will occur. The university hospitals and medical staffs for the most part are not yet able to educate students by providing effective examples of the various contracts in medical care which I have discussed. Further modifications in the role and style of operation of the academic medical centers are necessary before these centers educate students in the new contractual understandings and new conventions which comprise the system within the systems of medical care and personal health services.

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